Summary of Mental Health Benefits for The City of Montgomery

Effective June 1, 2020 **Summary Document #:** 835090364822

IMPORTANT INFORMATION: 1. All benefits are based on the appropriate level of care and medical necessity guidelines. Provider/facility licensure by the state to provide covered services and facility accreditation by The Joint Commission or CARF is required. 2. In-network and out-of-network days/visits/units shall not be combined so that the combination exceeds the total number of days/visits/units available in this section of the *Mental Health and Substance Abuse Benefits Summary*

	In-Network	Out-of-Network
INPATIENT HOSPITAL FACILITY SERVICES		
• Acute Inpatient Hospitalization • Inpatient Electroconvulsive Therapy (ECT) • Partial Hospitalization/Day Treatment (PHP) **PHP: One (1)** PHP Day Equals **One (1)** Inpatient Day	**Pre-admission Certification Required** **Call 800-677-4544** Covered At **100%** Of Allowed Amount* After Copay **Patient Responsibility:** • **Days 1-3: $100** Per Day Copay • **Days 4-19: Full Coverage** • **Days 20-30: $25** Per Day Copay	**Pre-admission Certification Required** **Call 800-677-4544** Covered At **50%** Of Allowed Amount* **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*
Intensive Outpatient Program (IOP)	**NOT COVERED**	
PROFESSIONAL SERVICES		
• Outpatient Office Visits • Psychological/Neuropsychological Testing **Precertification Required** for Psychological/Neurological Testing if more than **five (5) hours** are requested or **services are provided by an out-of-network provider. Call 800-677-4544** **LIMITATIONS:** Up To **30** Visits/Sessions/ Group Therapy Sessions (Or Any Combination Thereof) Total for Outpatient Mental Health Care **Each Contract Year**	Covered At **100%** Of Allowed Amount* After Copay **Patient Responsibility:** • **Visits 1-5: $5** Copay Per Visit • **Visits 6-20: $20** Copay Per Visit • **Days 21-30: $35** Copay Per Visit	Covered At **50%** Of Allowed Amount* **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*
Inpatient Physician Services in Conjunction with Approved Inpatient Services **LIMITATIONS:** Up To **30** Days Total for Inpatient Mental Health Care **Each Contract Year,** and Up to **60** Days Total for Inpatient Mental Health Care Per Lifetime	Covered At **100%** Of Allowed Amount* **Patient Responsibility: None**	Covered At **50%** Of Allowed Amount* **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*
Anesthesia in Conjunction with Approved ECT Treatment	Covered At **80%** Of Allowed Amount* Subject to the Inpatient Copay Amount **Patient Responsibility: 20%** Of Allowed Amount	Covered At **80%** Of Allowed Amount* **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*
COVERED BY MEDICAL PLAN		
• Ambulance • Emergency Dept. • Imaging • Lab Work	**COVERED BY THE CITY OF MONTGOMERY MEDICAL PLAN**	**COVERED BY THE CITY OF MONTGOMERY MEDICAL PLAN**
BEHAVIORAL HEALTH CARE MANAGEMENT		
Care management is a service offered by *the Plan* to assist you with difficult behavioral health care needs. You have a personal care manager who acts as your advocate, assisting you whenever you have questions or concerns. Call American Behavioral at 800-677-4544 to talk to your personal care manager.		

***Allowed Amount:** The maximum amount on which payment for covered health care services is based. The allowed amount can often be considerably less than a provider's actual charge, so when you use an out-of-network provider, you can incur substantial out-of-pocket expenses.

Summary of Substance Abuse Benefits for The City of Montgomery

Effective June 1, 2020

Summary Document # 492321101388

IMPORTANT INFORMATION

All benefits are based on the appropriate level of care and medical necessity guidelines.

	In-Network	Out-of-Network
INPATIENT HOSPITAL FACILITY SERVICES		
• Acute Inpatient Hospitalization/Substance Detoxification • Partial Hospitalization/Day Treatment (PHP) **LIMITATION:** Up To **21** Days Total per **12 Consecutive Months** Combined Inpatient Hospitalization/Substance Detoxification, PHP, and IOP	**Pre-admission Certification Required** **Call 800-677-4544** Covered At **100%** Of Allowed Amount* After Per Admission Deductible **Patient Responsibility:** **$500** per Admission Deductible	**NO OUT-OF NETWORK BENEFIT**
Intensive Outpatient Program (IOP) **LIMITATION:** Up To **21** Days Total per **12 Consecutive Months** Combined Inpatient Hospitalization/Substance Detoxification, PHP, and IOP	**Pre-admission Certification Required** **Call 800-677-4544** Covered At **100%** Of Allowed Amount* After Per Admission Deductible **Patient Responsibility:** **$150** per Admission Deductible	
NOTE: Family program and continuing care services are provided through American Behavioral. Call 800-677-4544 to initiate these services.		

***Allowed Amount:** The maximum amount on which payment for covered health care services is based. The allowed amount can often be considerably less than a provider's actual charge, so when you use an out-of-network provider, you can incur substantial out-of-pocket expenses.